MEDICAID ELIGIBILITY

Forward

Individuals who are recipients of Supplemental Security Income (SSI) are automatically eligible for Medicaid on the basis of their eligibility for that cash assistance program.

Basic Medicaid eligibility requirements are governed by the policies of the related cash assistance programs. As a general rule, policies of the AFDC program in place on July 16, 1996, apply to Medicaid determinations for families and children, while policies of the SSI program apply to Medicaid determinations for the aged, blind, and disabled.

Basic eligibility requirements for Medicaid are as follows:

1. Categorical

    a. Aged (Age 65 or over)

    b. Blind (Visual Acuity of 20/200 or less or limited visual field of 20 degrees or less, even with correction)

    c. Disabled (Unable to engage in substantial work activity for at least 12 months or a condition resulting in death)

    d. AFDC (deprivation of parental care and support)

    e. U-18 (under 18 years of age)

    f. Refugee Status

    g. Pregnant Women

    h. Newborn Infants

    i. ARKids First (children under 19 years of age)

2. Citizenship or Alienage - It must be verified that the individual or family is one of the following:

    a. Citizen of the United States

b. Qualified alien

c. Non-qualified alien in need of emergency services only

3. Income - The individual's or family's income after deduction of allowable exclusions cannot exceed the income standard of the applicable category.

4. Resources - The individual's or family's resources cannot exceed the resource limit of the applicable category.

5. Social Security Enumeration

6. Assignment of Third Party Liability Benefits

7. Cooperation with Child Support Enforcement when there is an absent parent.

FINANCIAL ELIGIBILITY REQUIREMENTS FOR THE MEDICALLY NEEDY

Medically Needy Resource Levels

Medically Needy Resource Levels vary by unit size (see page 4).

Resource Exclusions

Resource exclusions generally include the home, one automobile, household goods and personal effects. In certain cases, income producing property can also be excluded.

Medically Needy Income Levels

Medically Needy Income Levels vary by unit size (see page 4).

Income Deductions and Disregards

Income deductions and disregards generally follow the guidelines of the related cash assistance categories.

For the Under 18 Medically Needy (U-18-MN), Aid to Families with Dependent Children Medically Needy (AFDC-MN), Unemployed Parent (UP-MN), and Pregnant Women Medically Needy (PW-MN) programs, the income deductions of the AFDC cash assistance program apply. From earnings, a deduction of $90 per month is allowed. Actual child care expenses up to $175 per child per month for a child age 2 and older, and up to $200 per child per month for a child under age 2 are allowed for full-time and part-time employees.

The income and resources of the Aged, Blind, and Disabled Medically Needy (AABD-MN) applicant will be determined using Long Term Care policy in the 3000 section of the Medical Services Manual. The SSI related income deductions and SSI exclusions will be used for AABD-MN categories.

Spend Down - Individuals who meet categorical eligibility requirements and the Medically Needy resource requirements can achieve eligibility for Medically Needy even though their net income after deductions and/or disregards exceeds the Medically Needy Income Level. Eligibility for these persons is determined through a "Spend Down" procedure.

The Spend Down is a two step procedure where an individual can achieve eligibility by documenting that he has incurred medical expenses greater than the excess income he has above the Medically Needy Income Level. Medical expenses which cannot be paid by the Medically Needy program are deducted first, and then a chronological deduction of medical expenses which can be paid is completed to eliminate any remaining excess income.

MEDICALLY NEEDY INCOME AND RESOURCE LEVELS

The countable income and resource limitations for the Medically Needy program are as follows:

Unit Size	Monthly	Quarterly	Resources
1	$108.33	$325.00	$2000.00
2	216.66	650.00	3000.00
3	275.00	825.00	3100.00
4	333.33	1000.00	3200.00
5	383.33	1150.00	3300.00
6	441.66	1325.00	3400.00
7	500.00	1500.00	3500.00
8	558.33	1675.00	3600.00
9	616.66	1850.00	3700.00
10	675.00	2025.00	3800.00

For Unit Sizes above 10, add $58.33 per month and $100.00 to the income and resource levels, respectively, for each additional member.

ELIGIBILITY REQUIREMENTS FOR SOBRA - Pregnant Women (POVERTY LEVEL) CATEGORIES

1. Category 62 - Presumptive Eligibility (Pregnant Women Only)

    a. Verification of Pregnancy
    b. Income Limit

2. Category 61 - Pregnant Women

    a. Verification of Pregnancy (not required for children's eligibility)
    b. Income Limit
    c. Resources
    d. Citizenship or Alienage
    e. Residence Requirement
    f. Relationship and Living with Specified Relative (for children only)
    g. SSN Enumeration
    h. TPL Assignment
    i. CSE Referral

Income and resources will be computed according to AFDC income guidelines. A $90 earned income deduction and a deduction for child care expenses may apply.

SOBRA CATEGORY INCOME AND RESOURCE LEVELS
Monthly Standards - (Effective 04/01/02)

Number in Standard	200% of FPL	Resource Levels
1	1,476.66	$2000.00
2	1,990.00	3000.00
3	2,503.34	3100.00
4	3,016.66	3200.00
5	3,530.00	3300.00
6	4,043.34	3400.00
7	4,556.66	3500.00
8	5,070.00	3600.00
9	5,583.34	3700.00
10	6,096.68	3800.00
For additional people add:	513.34	100.00

ELIGIBILITY REQUIREMENTS FOR ARKIDS FIRST

There are two categories under the ARKids First program, ARKids A and ARKids B. The chart below provides a comparison of the coverage package for each:

Coverage	**ARKids A**	**Arkids B**
Basic Coverage: Physician, prescription drugs, hospital, ambulance (emergency only), dental, medical equipment, medical supplies, emergency department services, eye glasses, family planning, health screens, home health services, laboratory and x-ray, mental health –outpatient only, podiatry, speech therapy and vision, chiropractor, immunizations, nurse midwife and nurse practitioner.	***Yes***	***Yes***
Additional Coverage: Audiology, child health management services, developmental day treatment clinic services, domiciliary care, end stage renal disease services, hearing aids, hospice, hyperalimentation, inpatient psychiatric, nursing facilities, orthotics, personal care, transportation (non-emergency), private duty nursing, prosthetics, therapy (occupational and physical), ventilator services, and targeted case management.	***Yes***	***No***
Screenings (through Child Health Services): If the child receives periodic Child Health Services checkups, benefits are unlimited for covered services that are medically necessary.	***Yes***	***No***
Co-payments: ARKids B requires the following co-payments: $5.00 per prescription drug, $10.00 per medical visit, $10.00 per emergency ambulance trip, 20% of the 1st day of inpatient hospitalization, 20% of the Medicaid allowed amount for each item of Durable Medical Equipment. A co-payment is not required for preventive health screens and family planning services.	***No***	***Yes***

ARKIDS FIRST (CONTINUED)

The following chart summarizes the eligibility requirements for the two ARKids First categories:

Summary of Eligibility Criteria

	ARKids A		ARKids B
Age Limit	For children under 19 born after 9/30/82.		For children under 19
Income Limit*			
# in Family	**Under 6**	**6 and Over**	
1	981.98	738.33	1,476.66
2	1,323.35	995.00	1,990.00
3	1,664.72	1,251.67	2,503.34
4	2,006.08	1,508.33	3,016.66
5	2,347.45	1,765.00	3,530.00
Each additional member add	341.37	256.67	513.34
Income Deductions	$90 from earned income Child care deductions $50 for child support		$50 for child support
Asset Limit	No Asset Test		No Asset Test
Insurance	May have insurance and still be eligible. Insurance pays before ARKids A.		Not eligible if child has comprehensive group or employer-based insurance. If group or employer based insurance dropped, 6 month waiting period except where insurance was terminated involuntarily.
Citizenship/Qualified Alien	Yes		Yes
AR Resident	Yes		Yes
Relationship/Living with Specified Relative	Yes, unless a non-relative has custody or guardianship.		

* Income limits will be adjusted on April 1, 2003.

FAMILY PLANNING DEMONSTRATION WAIVER PROGRAM

SUMMARY OF ELIGIBILITY

Eligibility under the Family Planning Waiver is limited to women who are not certified in any other Medicaid category and who are at risk for unintended pregnancy. It will not be necessary to redetermine eligibility for postpartum family planning services for women previously certified in a pregnant woman Medicaid category, as long as they request services no later than the last day of their postpartum period.

For new applicants, the following eligibility requirements must be met:

1. Income – Net income cannot exceed 133% of the Federal Poverty Income Guidelines for the appropriate number of persons included in the budget. Refer to the chart on page 5 for these amounts.

2. Resources – The Medically Needy Resource Levels are the standards used. Refer to the chart on page 4 for these amounts.

3. Citizenship or Alien Status – The woman must be a citizen or a qualified alien.

4. Residency – The woman must be an Arkansas resident.

5. Social Security Enumeration – The woman must meet the SSN requirements.

6. Mandatory Assignment of Rights to Medical Support – The woman must assign her rights to any third party liability

Women certified under the Family Planning Waiver will remain eligible until September 2002, or for the duration of the demonstration project. Loss of eligibility will occur only when the eligible individual moves from Arkansas, becomes pregnant, becomes eligible in another category, requests closure, or dies.

BREAST AND CERVICAL CANCER MEDICAID

SUMMARY OF ELIGIBILITY

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (BCCPTA) authorizes states to provide Medicaid benefits to uninsured women under age 65 who are in need of treatment for breast or cervical cancer. In Arkansas, this program is an expansion of the Breast Care program administered by the Arkansas Department of Health. It includes a federally funded program that covers breast and cervical cancer screening and diagnosis as well as a state program that covers breast cancer screening, diagnosis and treatment.

For new applicants, the following eligibility requirements must be met:

1. Screening - The woman must have been screened for breast or cervical cancer under the CDC Breast and Cervical Cancer Early Detection Program and found to need treatment for either breast or cervical cancer, including precancerous conditions.
2. Insurance - She must not have creditable insurance coverage or coverage in another Medicaid category. "Creditable Coverage" in this category is defined as insurance that pays for medical bills related to the diagnosis and treatment of breast or cervical cancer.
3. Age - She must be under age 65.
4. Residency - The woman must be a resident of the state of Arkansas.
5. Citizenship - She must be a US citizen or qualified alien as defined by Medicaid policy.
6. Enumeration - The woman must declare a Social Security number.
7. Third Part Liability - If the woman has insurance that is not considered creditable, she must assign right to Medical Support/Third Party Liability according to Medicaid policy.

Women interested in making application for the Breast and Cervical Cancer Medicaid program should call the toll free number for Breast Care at 1-877-670-CARE. The Arkansas Department of Health will schedule screenings and determine eligibility for the program as well as coordinate treatment for those found eligible.

TRANSITIONAL EMPLOYMENT ASSISTANCE (TEA) RELATED MEDICAID

Welfare reform legislation passed by Congress in 1996 replaced the Aid to Families with Dependent Children (AFDC) program with the Temporary Assistance for Needy Families (TANF) program. In Arkansas, TANF is known as Transitional Employment Assistance (TEA).

Low income families and children who receive cash assistance under TEA are not automatically entitled to Medicaid, as they were under AFDC. Certain individuals, however, may be Medicaid eligible in the TEA category if their net income and countable resources do not exceed the AFDC income and resource limits which were in effect on July 16, 1996, and if the children are deprived of the support of one or both parents.

Listed below are the eligibility requirements for the TEA Related Medicaid category:

1. Citizenship or Alien Status,

2. Social Security Enumeration,

3. Mandatory Assignment of Rights to Medical Support,

4. Cooperation with the Office of Child Support Enforcement (OCSE),

5. Residency,

6. Relationship and Living with Specified Relative (for children only),

7. Deprivation of Parental Support,

8. Resources (The total equity value of all countable resources cannot exceed $1000),

9. Income (See the U-18 chart on page 8 for the applicable income limits).

FINANCIAL ELIGIBILITY REQUIREMENTS

UNDER 18 CATEGORY

The Under 18 category provides medical services to children under 18 years of age who are financially needy according to the AFDC cash assistance program but do not qualify as dependent children.

A child in the Under 18 category does not have to be deprived of parental care and support due to the absence, disability or death of a parent.

U-18 Income Limits

Unit Size	Countable Income
1	81.00
2	162.00
3	204.00
4	247.00
5	286.00
6	331.00
7	373.00
8	415.00
9 or more	457.00

Resource Limit

Total countable resources cannot exceed $1000 for the assistance unit.

TEFRA

TEFRA provides for coverage of certain disabled children in the home if they would qualify for Medicaid as residents in a Title XIX Institution (e.g., nursing home, ICF-MR, etc.). This category of Medicaid eligibility enables children to have care in their homes rather than in an institution. Children who live in institutions or who receive extended care in institutions are not eligible in the TEFRA category.

ELIGIBILITY REQUIREMENTS

1. Age - The child must be 18 or under.

2. Disability - The child must be disabled according to SSI definition.

3. Citizenship or Alien Status - The child must be a citizen or a qualified alien.

4. Residency - The child must be an Arkansas resident.

5. Resources - The child's countable resources cannot exceed $2000.

6. Income - The child's gross countable income must be less than the current LTC income limit ($1635 per month in 2002), i.e., the child would be Medicaid eligible if institutionalized.

7. Medical Necessity - The child must meet the medical necessity requirement for institutional care, i.e., the child requires a level of care that would be provided in a hospital, nursing facility, or ICF-MR.

8. Appropriateness of Care - Medical services must be available to provide care to the child in the home, and it must be appropriate to provide such care outside an institution.

9. Cost Effectiveness - The estimated cost of care for the child in the home cannot exceed the estimated cost of care for the child in an institution.

10. Child Support Enforcement Referral - If there is an absent parent, a referral to Child Support Enforcement for the collection of medical support is required.

11. Social Security Enumeration - The child must meet the SSN requirements.

ELIGIBILITY REQUIREMENTS FOR MEDICARE SAVINGS CATEGORIES (QUALIFIED MEDICARE BENEFICIARIES (QMB), SPECIFIED LOW INCOME MEDICARE BENEFICIARIES (SMB), AND QUALIFYING INDIVIDUALS 1 (QI-1) & 2 (QI-2))

1. Categorical Relatedness

    a. Aged
    b. Blind
    c. Disabled

2. For QMB, entitled to or conditionally eligible for Medicare Part A Hospital Insurance. For SMB, QI-1, and QI-2, entitled to Medicare Part A Hospital Insurance *and* Part B Medical Insurance

3. Citizenship or Alien Status

4. SSN Enumeration

5. Residency

6. Resource Limit - twice the SSI resource limit

    a. Individual - $4000
    b. Couple - $6000

7. <u>Income Limits</u>

    Effective 4/1/02, the income limits are:

    QMB: $738.33 for an individual or
    $995.00 for a couple

    SMB: Greater than $738.83, but less than $886.00 for an individual, or
    Greater than $995.00, but less than $1194.00 for a couple

    QI-1: At least $886.00, but less than $996.75 for an individual, or
    At least $1194.00, but less than $1343.25 for a couple

    QI-2: At least $996.75, but less than $1292.08 for an individual, or
    At least $1343.25, but less than $1741.25 for a couple

8. Assignment of Third Party Liability

9. Child Support Enforcement Referrals

Resources and income are computed according to LTC guidelines.

These categories are not eligible for the full range of Medicaid services. QMBs are eligible for payment of Medicare premiums, deductibles and coinsurance. SMBs and QI-1s are eligible for payment of their Medicare Part B premium only. QI-2s are eligible for reimbursement of a *portion* of their Medicare Part B premium. Currently, this portion is $3.91 per month for calendar year 2002.

WORKING DISABLED

SUMMARY OF ELIGIBILITY

1. Be at least 16 years of age but under 65.

2. Be disabled according to the SSI definition of disability.

3. Be working.

4. Be a resident of the state of Arkansas.

5. Be a U.S. citizen or qualified alien.

6. Furnish a Social Security Number, or apply for one.

7. Have a net personal income less than 250% of the poverty level for his/her family size. Have a net personal **unearned** income less that the current SSI Standard for one ($545 for 2002)

8. Have countable resources equal to or less than twice the medically needy resource limit for his/her family size. Only the resources of the individual and the spouse will be counted.

9. Assign rights to medical support/third party liability.

Working Disabled Income/Resource Standards

Family Size	Income	Resources
1	$1,845.82	$4,000.00
2	$2,487.50	$6,000.00
For each additional family member add	$641.67	$ 200.00

ELDERCHOICES/HOME AND COMMUNITY BASED WAIVER PROGRAM

SUMMARY OF ELIGIBILITY

1. Aged - 65 years of age or older.

2. Intermediate Level of Care - Individuals must be classified as requiring an intermediate level of care if in an institution.

3. Income - Gross income cannot exceed $1635.00/month.

4. Resources - The countable resource limit for an individual is $2000, and $3000 for a couple.

5. Citizenship - It must be verified that the individual is a citizen of the United States or a qualified alien.

6. Residency - The individual must be a resident of Arkansas.

7. Social Security Enumeration.

8. Cost Effectiveness - The average cost of services provided to individuals in the community must be less than the cost of services for those individuals if they were in an institution.

DDS ALTERNATIVE COMMUNITY SERVICES WAIVER PROGRAM

SUMMARY OF ELIGIBILITY

1. Must be developmentally disabled.

2. SSI cash payment recipients, or aged, blind, or disabled individuals who would be Medicaid eligible if in an institution.

3. Citizenship - Citizen of the United States or a qualified alien.

4. Residency - Resident of Arkansas.

5. Social Security enumeration.

6. Child support enforcement requirement.

7. Income - Gross income cannot exceed $1635.00/month. Income is determined and verified according to LTC guidelines.

8. Resources - The countable resource limit is $2000 for an individual, $3000 for a couple. Resources are determined and verified according to LTC guidelines.

9. Cost Effectiveness - The average cost of services to the individuals in the community must be less than the average cost of services to individuals in an ICF/MR facility.

10. ICF/MR Level of Care - Individuals must be determined to require an ICF/MR level of care.

11. Must receive waiver services. Medicaid only cannot be provided to an individual who is otherwise eligible for a waiver program but who is not receiving (or will not receive) waiver services.

ALTERNATIVES FOR ADULTS WITH PHYSICAL DISABILITIES WAIVER

SUMMARY OF ELIGIBILITY

1. SSI cash payment recipients, or blind or disabled individuals who would be Medicaid eligible if in an institution.

2. Must be physically disabled.

3. Age – 21 through 64 years of age.

4. Intermediate Level of Care – Individuals must be classified as requiring an intermediate level of care if in an institution.

5. Income – Gross income cannot exceed $1635.00/month. For those individuals not in receipt of SSI, income is determined and verified according to LTC guidelines.

6. Resources – The countable resource limit is $2000 for an individual and $3000 for a couple. Resources are determined and verified according to LTC guidelines.

7. Citizenship – Citizen of the United States or a qualified alien.

8. Residency – Resident of Arkansas.

9. Social Security Enumeration.

10. Mandatory Assignment of Rights to Medical Support/Third Party Liability.

11. Cost Effectiveness – The average cost of services provided to individuals in the community must be less than the cost of services provided in a nursing facility.

AABD LONG TERM/NURSING FACILITY CARE

SUMMARY OF ELIGIBILITY

1. Institutional Status - It must be verified that the individual has been institutionalized for 30 consecutive days.

2. Categorical Relatedness - The individual must be:

   a. Aged (Age 65 or over); or
   b. Blind (Visual Acuity of 20/200 or less or limited visual field of 20 degrees or less, with best correction); or
   c. Disabled (unable to engage in substantial gainful work activity for at least 12 months as determined by SSA or MRT.)

3. Citizenship or Alien Status - It must be verified that the individual is one of the following:

   a. Citizen of the United States; or
   b. Qualified alien.

4. Medical Necessity for Nursing Facility Care - The individual must be in need of a level of care covered by the state's plan for nursing facility care services.

5. Residency - The individual must be an Arkansas resident.

6. Income Limit - The individual's gross income cannot exceed $1635.00/month, unless an income trust is established. All income of the individual except VA Aid and Attendance and VA CME/UME is considered in determining eligibility.

7. Resource Limit - The countable resource limit for an individual is $2000. Resources include real property, cash, checking and/or savings accounts, certificates of deposit, promissory notes, mortgages, stocks, mutual fund shares, bonds, trusts, etc. owned by the individual. Resources may also include autos, and Life Insurance policies with cash value.

   Resources Exclusions include:

_____ The home if it remains the principal place of residence, or is the residence of a spouse or dependent relative, or as long as the individual states his intent to return.

_____ One auto with NADA wholesale value of $4500 or less, or regardless of value when used for medical transportation, work transportation or it is specifically equipped for the disabled.

_____ Total of all life insurance policies with total face value of $1500 or less. (Only concerned with policies which have cash surrender value).

_____ Burial Space.

_____ Burial fund account up to $1500. Excluded value reduced by value of other burial arrangements and the value of any excluded life insurance. An amount larger than $1500 may be excluded if in a prepaid irrevocable burial policy.

_____ Household goods and personal effects up to $2000.

_____ Income producing property. Real and/or personal property may be excluded if used in a trade or business enterprise.

8. Transfer of Property - If an institutionalized individual transferred real or personal property at less than fair market value to a person other than a spouse in the 36 month period preceding application, the uncompensated value will be divided by 1700 to determine a period of ineligibility. If a transfer was made 10/01/89 or later to a spouse living in the community, no period of ineligibility will be imposed for institutionalized individuals. However, the combined total resources could make the institutionalized spouse ineligible for assistance.

APPLICATION FOR ASSISTANCE

Application for assistance should be made at the Department of Human Services Office in the county where the nursing facility is located. A telephone call to the DHS office is advisable to determine if an appointment is necessary.

YOUR GUIDE TO LONG TERM CARE MEDICAID

APPLICATION PROCESS

This is a reference for general rules and regulations regarding the placement of an individual into long term care under Medicaid. Please keep in mind that these regulations are for the current year of 2002.

INCOME

The income limit is $1635 per month in 2002, unless an individual establishes an income trust. Income includes such benefits as Social Security, veteran's benefits, railroad retirement, pensions, dividends, interest, rental income, payment from trust, insurance policies, contributions, etc. Gross income is considered when determining the individual's eligibility. All income is paid to the nursing facility except for $40, which is a personal allowance to the client. (If an individual has a spouse remaining in the community, an allowance may also be made for his or her needs.) Therefore, any time there is an increase in income, that increase is paid to the nursing facility. If an individual needs assistance with an expense that cannot be paid with the $40 allowance, that assistance should be paid directly to the vendor or provider.

RESOURCES

The resource limit is $2000 for an individual. For a couple entering long term care in the same month, the resource limit is $3000 for the month of entry. In the month following admission, the couple is considered separated, and each has a resource limit of $2000. When only one individual of a couple enters long term care, their *combined* resources are considered according to these general rules, effective January 1, 2002:

If total resources are under $17,856 - spouse gets all.
If total resources are $17,856 to $35,712 - spouse gets $17,856.
If total resources are $35,712 to $178,560 - spouse gets one-half.
If total resources are over $178,560 - spouse gets $89,280 (Maximum as of 1/1/02).

The resource limit is considered only on the first day of the month. If resources are not below the limit on the first day of the month, the long term care individual will not be eligible for the entire month.

Resources include any property to which the individual has interest, including real property (home, non-home, and heir), bank accounts, stocks, bonds, certificates of deposit, burial funds, insurance policies, vehicles (trucks, cars, boats, campers, etc.), livestock, cemetery spaces, trusts, cash, etc. Each type of resource has certain disregards. The person conducting the interview or processing the application will advise you as to how these disregards apply to the particular resource in question. Although a particular asset may be able to be disregarded, documentation of the asset must be provided or the application will be denied.

A transfer of assets must be documented to establish whether the transfer occurred within 36 months of application (or 60 months, if transferred to a trust). For most transfers occurring within this 36-month period, compensation for the market value of the item transferred must be established. Compensation must be in a tangible form. When a transfer of an asset is determined not to be compensated, a disqualification period will be established.

INSTITUTIONAL STATUS

The individual entering long term care must stay for 30 days in order for Medicaid to be able to pay. Any hospital days will count toward the 30-day requirement as long as a transfer is made directly from the hospital to the long term care facility. Once the 30-day requirement is met and all other eligibility factors are met, payment by Medicaid to the long term care facility can begin with the date of entry.

MEDICAL NECESSITY

The last major requirement is medical necessity for long term care placement. This is determined by medical information submitted by the physician and the long term care facility.

GENERAL INFORMATION

The Department of Human Services (DHS) does not regulate payment to the long term care facility while eligibility is being determined. Some facilities require either private rate payment or a deposit which will be refunded upon approval of Medicaid by DHS. Others will accept the individual's income less the $40 personal allowance. The form of payment should be discussed with the facility before admission.

All income will continue to go to the address to which it was going prior to long term care placement. Some facilities do not want to be responsible for receiving and cashing the patient's check, or keeping up with the $40 allowance. If you want to change the address so that income is received directly by the long term care facility, be sure this is acceptable to the facility before the change is made.

Long Term Care Medicaid includes payment to the long term care facility, benefits provided by the Medicaid card (drugs, hospital and physician's fees, etc.), and payment of the Medicare premium beginning with the third month of Medicaid eligibility. If the Medicare premium is still being withheld from the individual's Social Security check in the fifth month after Medicaid approval, contact your local DHS office.

For questions regarding what is included in the vendor payment to the long term care facility or what is covered by the Medicaid card, call 682-8480. For complaints regarding care and the long term care facility, call 682-8425.